

~~Post Traumatic Stress Disorder (PTSD), Children, and Health Care Settings~~

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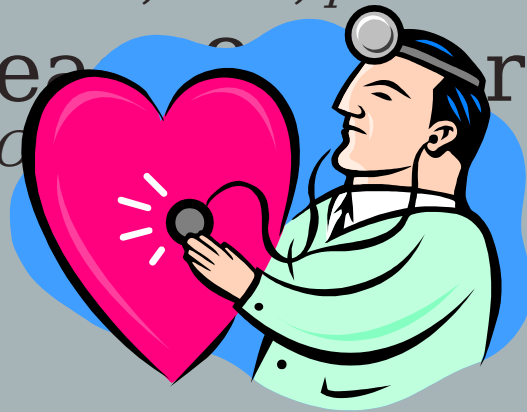
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Psychological Services within the Medical Model?

- ▶ The call for social workers to address “the social and psychological aspects of disease” (*Cabot, 1928, p. 265 as cited in Cowles, 2003*) is at least 100 years old (*Cannon, 1923 as cited in O’Neil, 2003*)



Pediatrics & PTSD

- ▶ PTSD in children is a well-known phenomena (40-70% prevalence)

(Jenkins & Bell, 1994 as cited in Feeny, Foa, Treadwell & March, 2004).

- ▶ Cause of PTSD is trauma *(American Psychiatric Association, 2004).*

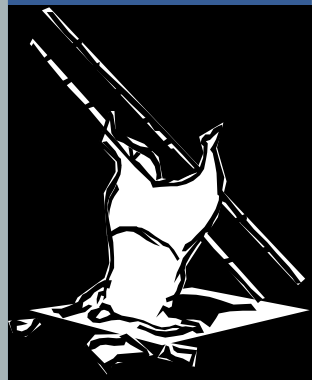
- ▶ Adolescents admitted to hospitals often present due to trauma exposure (93%) *(Lipschitz,*

Winegar, Hartnick, Foote & Southwick, 1999).

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Factors Related to Trauma in Children

- ▶ **Child Abuse** (40.2% of childhood hospitalizations (*Rovi, Ping-Hsin & Johnson, 2004*) - 2.7 Years Old
 - ▶ Children in **Auto Accidents** (29.2% meet criteria for PTSD / 17.7% criteria for depression) (*Stallard, Salter & Veleman, 2004*) - 14.85 Years Old
 - ▶ PTSD is found in children who have been **burned** (*Stoddard, Norman, Murphy & Beardslee, 1989*); who have had **transplants** (*Stuber, Nader, Yasuda, Pynoos & Cohen, 1991*); and who have had **cancer** (*Stuber, Meeske, Gonzalez,*
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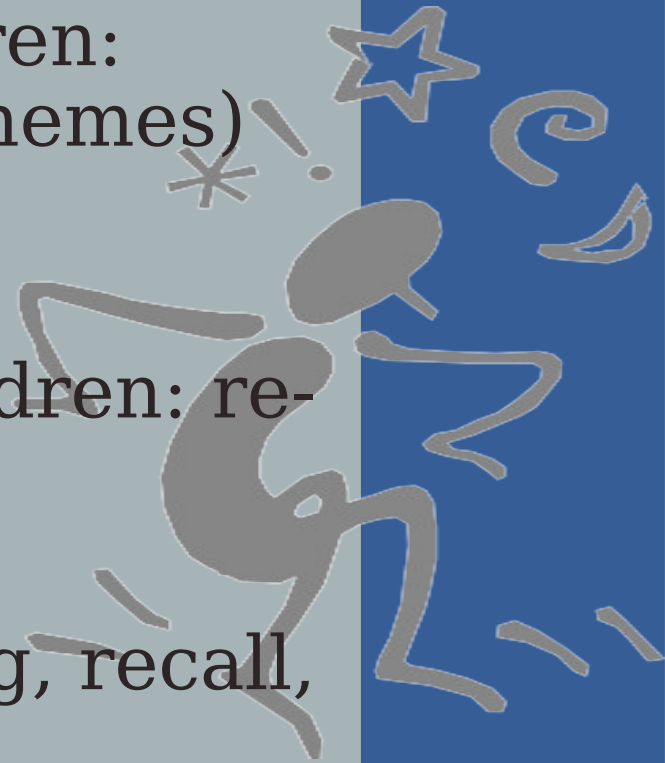


PTSD Symptoms

(Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2004)

- ▶ Response of intense fear (children: disorganized/agitated behavior)
- ▶ Intrusive recollections (children: repetitive play with trauma themes)
- ▶ Recurrent dreams (children: frightening)
- ▶ Re-experiencing trauma (children: re-enactment)
- ▶ Intense distress at cues
- ▶ Avoidance of stimuli, numbing, recall, affect
- ▶ Sleep, irritability, concentration, startle

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Problems in Pediatric Healthcare Research

★ Studies focus either on upper SES youth w/ prepaid health insurance plans

★ Or on lower SES youth w/ health insurance plans (Janice Finney, 2000)



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Problems in Pediatric Healthcare Research

- ✦ A lot of PTSD research has been about children who have been sexually abused (*Feeny, Foa, Treadwell & March, 2004*).
- ✦ PTSD diagnosis/treatment in hospitals - for pediatric patients research is very sparse (*Aaron, Zaglul & Emery, 1999*)



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Barriers to Diagnosis and Treatment

✦ Primary focus in healthcare is biology – not psychology, PIE, or social welfare

✦ “Intrapsychic processes” hard to observe and measure *(Smallbone & McCabe, 2003, p.3)*

✦ Classical psychoanalysis can increase mortality in patients *(Mohr 1995)*
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Barriers to Diagnosis and Treatment

- ✦ Lack of research suggests difficulties with validity and generalizability (*Fortune & Reid, 1999; Rubin & Babbie, 2001*)
- ✦ PTSD & depression symptoms often overlap (*Kulka et al., 1990 and Keane & Kaloupek, 1997 as cited in Kimble, Riggs & Keane, 1998*)
- ✦ Treatments applied in ER/Acute situations - often require tx before dx (*Tripodi & Epstein, 1980*).
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Reasons to Diagnose and Treat

- ✦ Adults and children respond similarly to life stressors (*Garnefski, Legerstee, Kraaij, van den Kommer, & Teerds, 2002*)
- ✦ Research suggests that like symptom overlap (depression / PTSD) there is treatment efficacy overlap (between adults / children) (*Lewinsohn & Clarke, 1999; Stein et al., 2003*)
- ✦ Psychological recovery impacts physical recovery (*Cowles, 2003; "E" 1992; Schmale, 1972*)



Need for Treatment

- ★ *PTSD can be Acute (1- 3 mos.) and/or Chronic (DSM-IV-TR, 2000)*
- ★ *Dx might also be Acute Stress Disorder (ASD); main difference between it and PTSD is time (2 days to 4 weeks) (DSM-IV-TR, 2000).*
- ★ *Many children are admitted to hospitals with physical injuries, experiencing PTSD symptoms – they need medical care and psychological*

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| *Care (Adron, Zagul & Finery, 1999).*

Need for Treatment

- ✦ Hospital costs for kids with trauma are double of other childhood treatments (\$19,266 vs. \$9,513)
- ✦ Hospital stays are twice as long as non-traumatized children (8.2 days vs. 4 days)
- ✦ Traumatized children more likely to **die** compared to peers
(Rovi, Ping-Hsin & Johnson, 2004)
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Diagnostic Tools

- ★ *Trauma Symptom Checklist for Children (TSCC)*
 - ★ *Identifies clients with PTSD with subscales for depression (54 items)*
 - ★ *Psychometrics strong; studied in hospital setting (Sadowski & Friedrich 2000)*
- ★ *Children's Depression Inventory (CDI)*
 - ★ *Used as a rule out or to find co-morbidity (27 items)*
 - ★ *Psychometrics are strong (Chorpita, Kim, Moffitt, Unemoto, & Francis, 2000, Siegel, 1986)*

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Diagnostic Tools

- ★ *Children's Impact of Traumatic Events Scale-Revised (CITES-R)*
 - ★ *Assess severity of trauma pre/post tx. (78 items) (Chaffin & Shultz, 2001).*
 - ★ *CROPS & PROPS*
 - ★ *Child **R**eport of **P**ost-Traumatic **S**ymptoms*
 - ★ *Parent **R**eport of **P**ost-Traumatic **S**ymptoms*
 - ★ *Tested on community sample (25/30 items) scales related to DSM*
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Treatment Intervention

- ▶ Behavioral therapy is more effective

(Kimble, Riggs & Keane, 1998; Muris, Meesters & van Melick, 2002)

- ▶ Treatment of choice

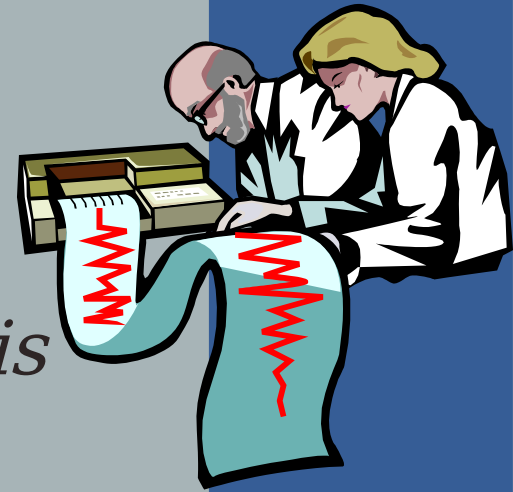
(Harvey, Bryant & Tarrier, 2003; Paunovic, 1999)

- ▶ EMDR (easy to do – young clients) effective w/ PTSD and anxiety – adults known – children more recently



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Valid Assessment & Treatment



★ Evidence Based Practice Debate is Ongoing

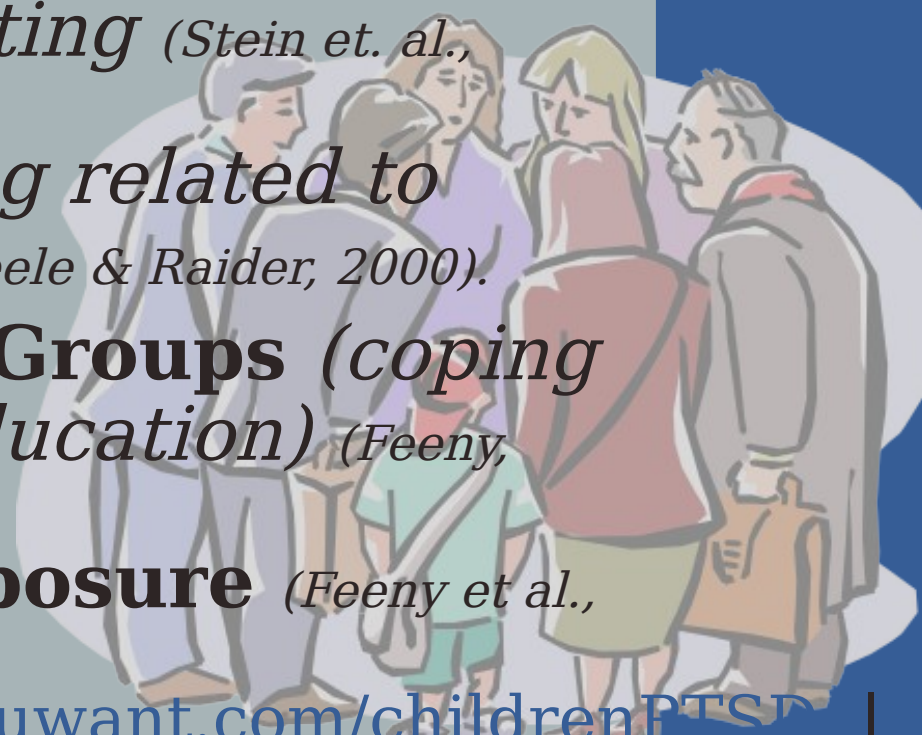
- ★ Research based - scientific method (*Klein, Bloom & Chandler, 1994*)
- ★ “Meta-Physical” – healing without proof of how it happens (*Heineman, 1981*)
- ★ The compromise is the “Scientist-Practitioner Model” – research and practice wisdom combined (*Allen-Meares, Yosikazu, & Siegel, 1994; Dangel & Bronson, 1994*)
- ★ Practitioners have to be more and more accountable (*Cowles, 2003*)

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treatment Intervention

- ★ **CBITS** - (*Cognitive Behavioral Intervention in Schools*) effectively treats PTSD & Depression in children in an institutional setting (Stein et. al., 2003)
- ★ **Art Therapy** (*drawing related to themes of trauma*) (Steele & Raider, 2000).
- ★ **Psychoeducational Groups** (*coping statements, illness education*) (Feeny, Foa, Treadwell & March, 2004).
- ★ **Imaginal/in vivo exposure** (Feeny et al., 2004)

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